

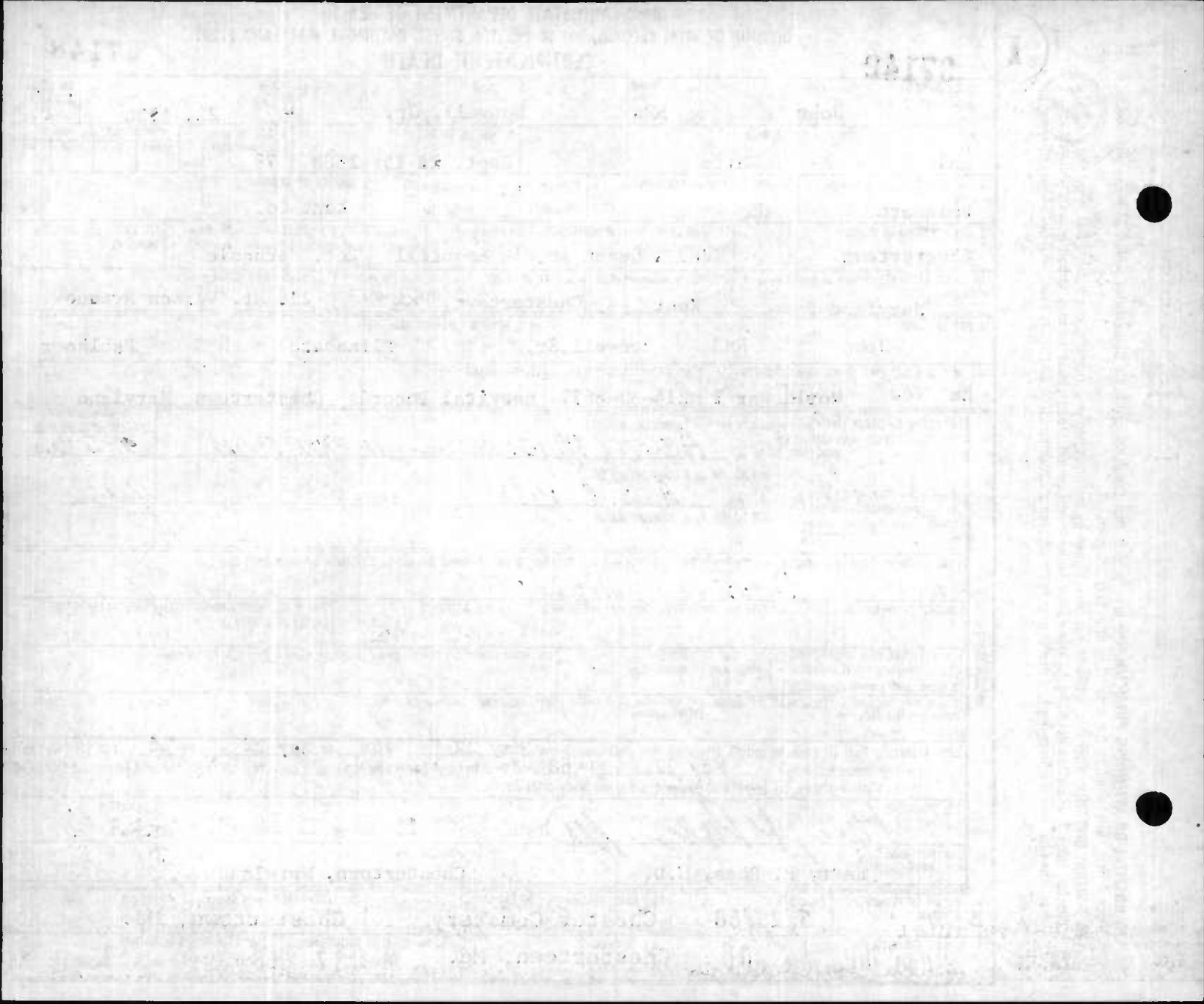
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First John	Middle NMN	Last Bedwell, Jr.	2a. DATE OF DEATH Month May Day 22, 1968 Year	2b. HOUR 1:00 P. M.
3. SEX		4. RACE Male White		S. DATE OF BIRTH Sept. 14 15, 1888	6. AGE (In years last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Delaware		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent Co.,	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Mechanic	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 216 Mt. Vernon Avenue	
14. FATHER'S NAME First John		Middle NMN	Last Bedwell, Sr.	15. MOTHER'S MAIDEN NAME First Elizabeth	Middle NMN	Last Faulkner
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. World War I		17. INFORMANT Hospital Records	Address Chestertown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A. S. C. V. D.</u> DUE TO, OR AS A CONSEQUENCE OF (c)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4-5 hrs</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>DIABETES MELLITUS</u>						
19a. DATE OF OPERATION 4/20/1		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from May 22, 1968, to May 22, 1968, that (I) (we) last saw the deceased alive on May 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Harry P. Ross, M.D.</i>		22c. DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>5-25-68</i>
22d. PHYSICIAN'S NAME (Type) <i>Harry P. Ross, M.D.</i>		22e. ADDRESS Chestertown, Maryland				
23a. BURIAL, CREMATION, B. REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5/25/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Chester Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Chestertown, Md.</i>		
24. FUNERAL DIRECTOR <i>J. Willis Wells</i>		ADDRESS <i>Chestertown, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>MAY 27 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. If pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First James	Middle Bond	Last	2a. DATE OF DEATH Month 5		2b. HOUR Day 27	Year 68		
3. SEX		4. RACE Colored		S. DATE OF BIRTH 8/25/1890	6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. DAYS 0	
7a. BIRTHPLACE (State or foreign country) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Kent County					
10. CITY OR TOWN OF DEATH R.F.D. Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) At Home		12a. USUAL OCCUPATION (Kind of work done during working life, even if retired.) Labor		12b. KIND OF BUSINESS OR INDUSTRY Factory				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN R.F.D. Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.F.D.		
14. FATHER'S NAME First John		Middle Robert	Last Bond	15. MOTHER'S MAIDEN NAME First Meta		Middle Speller	Last 			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. Florine Bond		Address R.F.D. #		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ <i>Inanition</i> <i>Cancer of pancreas and</i> <i>metastasis to liver and abdm. glands</i></p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 157X</p>										
19a. DATE OF OPERATION 157X		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State		
<p>22o. I certify that (I) (this hospital) attended the deceased from 5-22-67, 19-, to 5-20-1968, that (I) (we) lost saw the deceased alive on 5-20-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>										
22b. SIGNATURE Rudolfs Egutis M.D.		ATTENDING PHYS. D		22c. MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5-22-68				
22d. PHYSICIAN'S NAME (Type) Rudolfs Egutis M.D.		22e. ADDRESS Rock Hall, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/1/1968		23c. NAME OF CEMETERY OR CREMATORIAL 7777 Old Maryland Cem.		23d. LOCATION (City or Town) Bertie Co., N. Carolina		(County)	(State)	
24. FUNERAL DIRECTOR Smith, W.		ADDRESS Chestertown, Md.		25. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE JUN 3 1968				

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print)		First Elsie	Middle Hammond	Lost Bramble	2a. DATE OF DEATH Month May	Day 18	Year 1968	2b. HOUR 12:15 AM AM
3. SEX Female		4. RACE White		S. DATE OF BIRTH November 22, 1897	6. AGE (In years last birthday) 70	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent Co.,			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Town Clerk		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Kent	13c. CITY OR TOWN Betterton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER None			
14. FATHER'S NAME First Samuel		Middle James	comly Bramble	15. MOTHER'S MAIDEN NAME First Mary	Middle Elizabeth	Lost Moore		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 220-12-1924		17. INFORMANT Hospital Records	Address Chestertown, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma left lung</i> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>unknown</i> last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) </p>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 163x								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> <i>partner</i> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from April 8 , 1968, to May 18 , 1968, that (I) (we) last saw the deceased alive on May 18 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>A. C. Dick</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED 5-18-68								
22d. PHYSICIAN'S NAME (Type)		A. C. Dick, M.D.		22e. ADDRESS Chestertown, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-21-68	23c. NAME OF CEMETERY OR CREMATORIAL STILL POND CEMTY		23d. LOCATION (City or Town) STILL POND KENT MD.	(County) KENT	(State) MD.	
24. FUNERAL DIRECTOR VICTOR N. KENNEDY		ADDRESS STILL POND, MD.		25a. REC'D BY REGISTRAR DATE MAY 21 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 days after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that Page 4 may be retained by the hospital or attending physician.

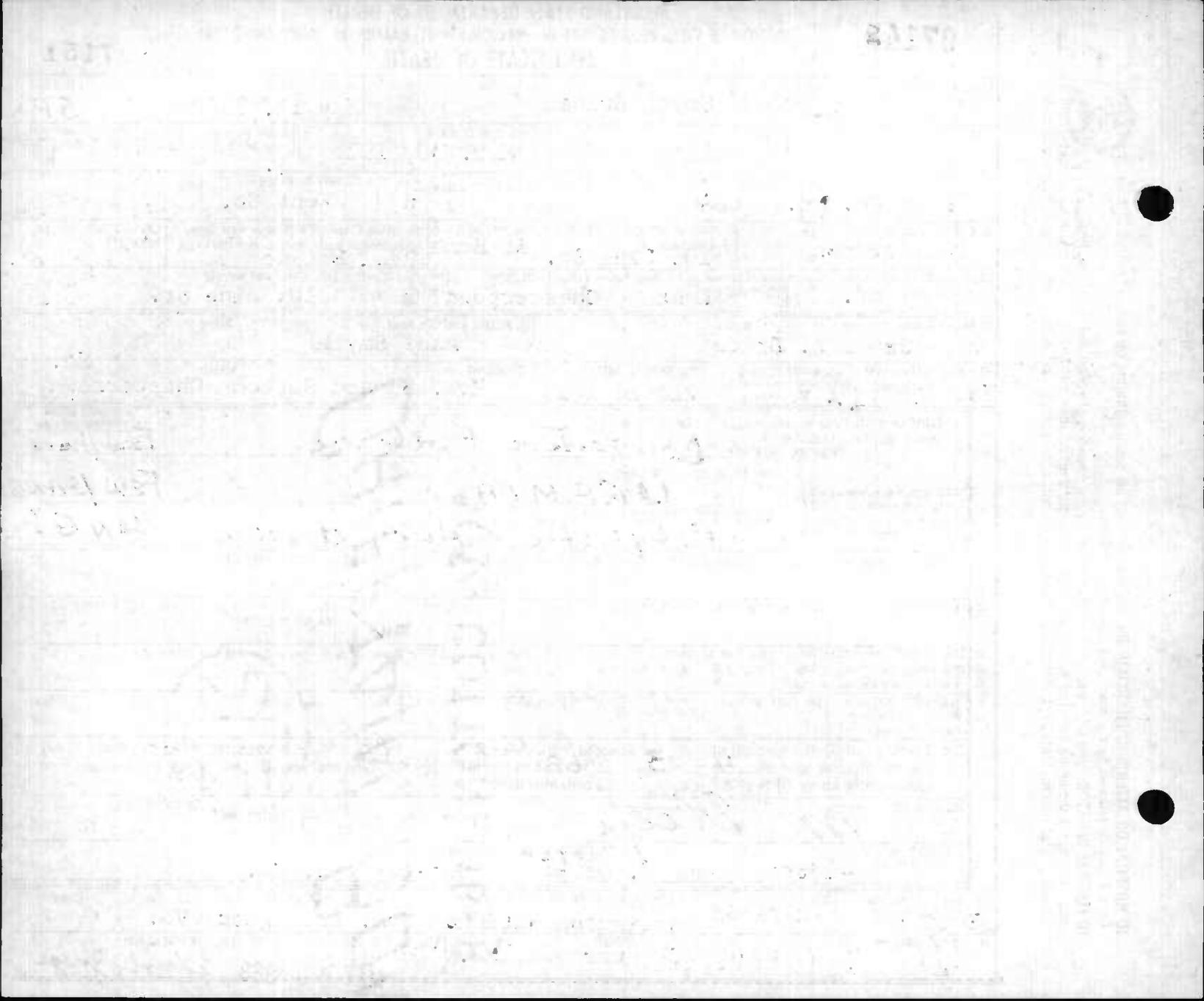
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Lawrence Smyth Brice						May 17, 1968		5 P.M.		
3. SEX male		4. RACE white		5. DATE OF BIRTH Mar. 30, 1921		6. AGE (In years last birthday) 47		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Kent Co. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Kent Co.				
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 105 Pine St. At Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Real Estate		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 105 Pine St.		
14. FATHER'S NAME James A. Brice		First Middle Last		15. MOTHER'S MAIDEN NAME Anna Smyth		Middle		Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes, WW II & Korea		16b. SOCIAL SECURITY NO. 213 14 1413		17. INFORMANT Mrs. Bayard Sutton		Address Chestertown,		Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Failure</u> 7484 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>UREMIA</u> (b) <u>POLYCYSTIC KIDNEY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CONG?</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH FEW Hours FEW YEARS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7571										
19a. DATE OF OPERATION 7571		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>4-22</u> , 19 <u>68</u> , to <u>4-23</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4-23</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>J.R. Oteiza</u>		DEGREE OTELZA		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		22c. DATE SIGNED 5/17/68
22d. PHYSICIAN'S NAME (Type) Jorge A. Oteiza		22e. ADDRESS Chestertown, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/21/1968		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem.		23d. LOCATION (City or Town) Arlington, Va.		(County) (State)		
24. FUNERAL DIRECTOR <u>Doris Wells</u>		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE MAY 21 1968 <u>Charles Judge</u>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR P.M.
Elizabeth		X	M.	Brown	May 7, 1968	2:05
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday) 68	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Female	White	Sept. 18, 1899			YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Penna.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Kent Co.		
10. CITY OR TOWN OF DEATH <i>Chestertown</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Kent & Queen Anne's Hospital Ass. Food Manager</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Balto. chesterwoman</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>College</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Kent</i>	13c. CITY OR TOWN <i>Balto.</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>7817 Aiken Ave.</i>	13f. ADDRESS <i>Indoor Street</i>	
14. FATHER'S NAME First <i>?</i>	Middle <i>Marter</i>	Last	15. MOTHER'S MAIDEN NAME First <i>Fannie</i>	Middle	Last <i>Bramble</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT <i>Hospital Records</i>			Address <i>Chestertown, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i>						
4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF <i>A-S. C.V.D.</i>						
DUE TO, OR AS A CONSEQUENCE OF <i>(c)</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from May 7, 1968, to May 7, 1968, that (I) (we) last saw the deceased alive on May 7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>A. T. Keefe, M. D.</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>5-7-68.</i>	
22d. PHYSICIAN'S NAME (Type) <i>Dr. A. T. Keefe, M. D.</i>		22e. ADDRESS <i>Chestertown, Maryland</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5/10/68.</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Gardens of Faith Cemetery</i>	23d. LOCATION (City or Town) <i>Baltimore, Md.</i>	(County)	(State)
24. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>		ADDRESS	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE <i>MAY 8 1968</i>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

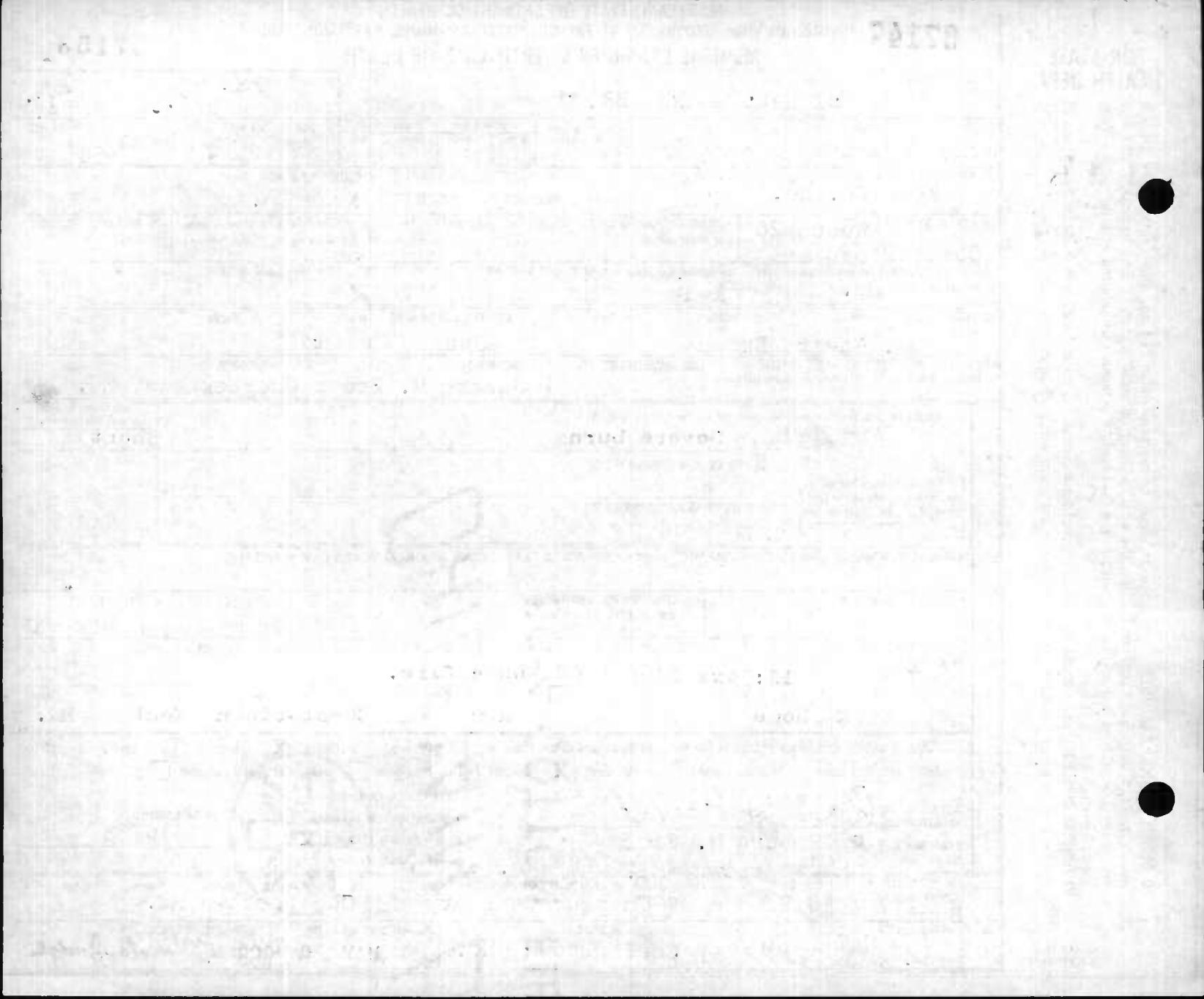
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07147 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07153

1. DECEASED NAME (Type or Print)			First	Middle	Lost	2a. DATE KNOWN OF DEATH ESTI- MATED		Month	Day	Year	2b. HOUR		
MICHAEL GLENN BROWN						<input checked="" type="checkbox"/>	5/6/68	19	11	30			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		Month	Day	Year	2d. HOUR		
male	white	9/6/64	3 YRS.	MONTHS	DAYS	HOURS	MIN.	5	6	1968	M		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		<input type="checkbox"/> NEVER MARRIED		9. COUNTY OF DEATH					
Kent Co. Md.		USA		<input type="checkbox"/> WIDOWED		<input type="checkbox"/> DIVORCED		Kent Co.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Route 20 Chestertown						none							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Kent			Chestertown			<input type="checkbox"/> YES <input type="checkbox"/> NO							
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost			
Wm. Edward Brown						Janice Russum							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT			ADDRESS				
no			no			Janice R. Brown			Chestertown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe burns 890 X Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Short	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 9160													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town County State				
			home			RFD			Chestertown Kent Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE			Robert W. Farr			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED				
EXAMINER'S NAME (Type)			Robert W. Farr Chestertown, Md. Kent Co.			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			5/6/68				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery			23d. LOCATION (City or Town) (County) (State)				
Burial			5/9/68						Chestertown, Md.				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
J.Wells Wells			Chestertown, Md.			DATE 5/11/68			Charles Judge				

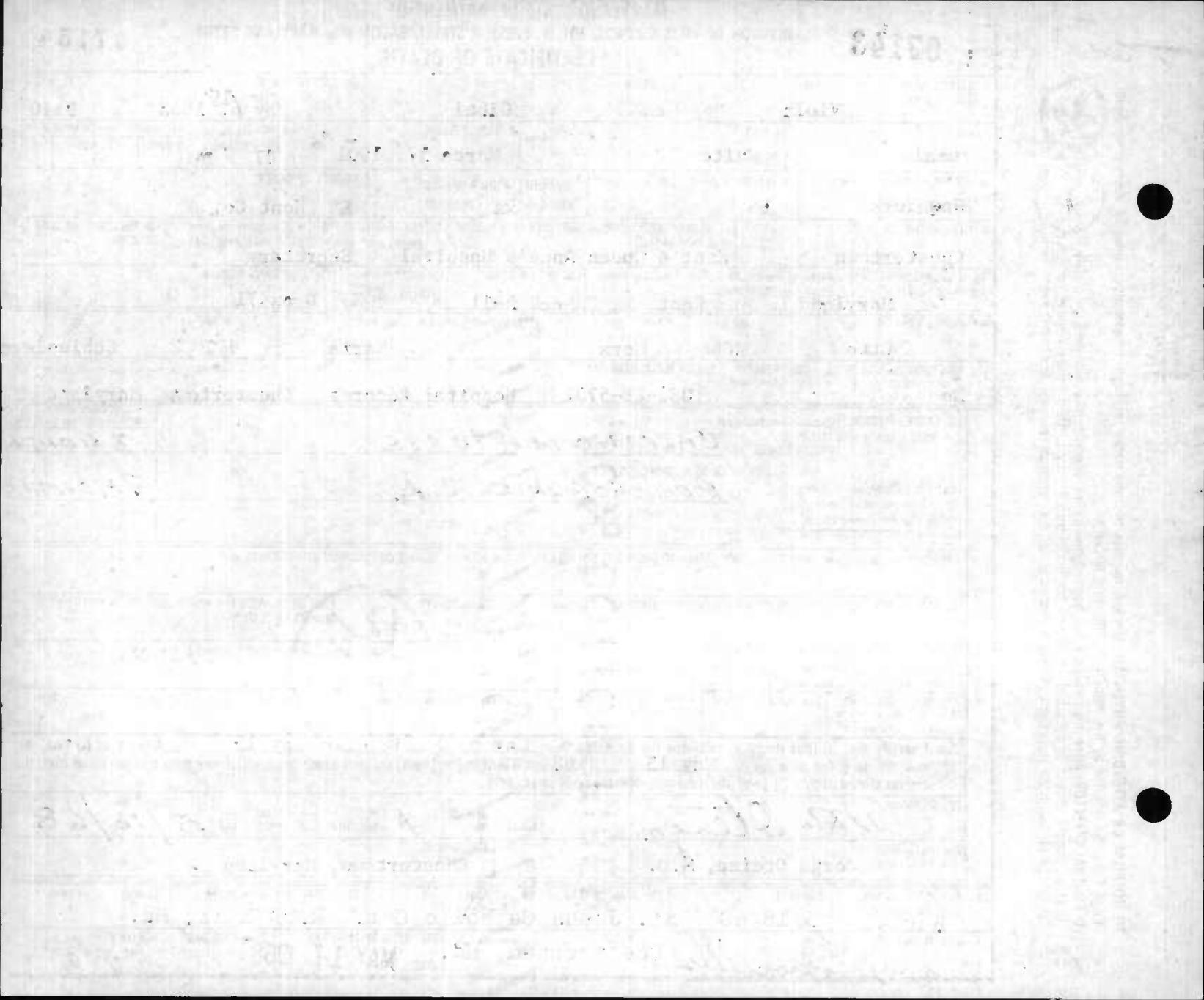


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1		07143		07154				
1. DECEASED-NAME (Type or print)		First Viola	Middle NMN	Last Gibel	2a. DATE OF DEATH Month May Day 15 Year 1968	2b. HOUR 9:10 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 17, 1901		6. AGE (In years last birthday) 67 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN
7b. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Kent Co.		
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Secretary		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 71
14. FATHER'S NAME First Otto		Middle NMN	Last Marx	15. MOTHER'S MAIDEN NAME First Maria		Middle NMN	Last Schlesiere	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 082-28-5701		17. INFORMANT Hospital Records		Address Chestertown, Maryland		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA TOSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHOGENIC CA. DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1621								
19a. DATE OF OPERATION 1621		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from May 6 , 19 68 , to May 15 , 19 68 , that (I) (we) last saw the deceased alive on May 15 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE J. Oteiza		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 5/16/68		
22d. PHYSICIAN'S NAME (Type) Jorge Oteiza, M.D.		22e. ADDRESS Chestertown, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/18/68		23c. NAME OF CEMETERY OR CREMATORIAL \$t. Johns Catholic Cem.		23d. LOCATION (City or Town) Rock Hall, Md.		(County) (State)
24. FUNERAL DIRECTOR J. Willis Wells		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE MAY 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



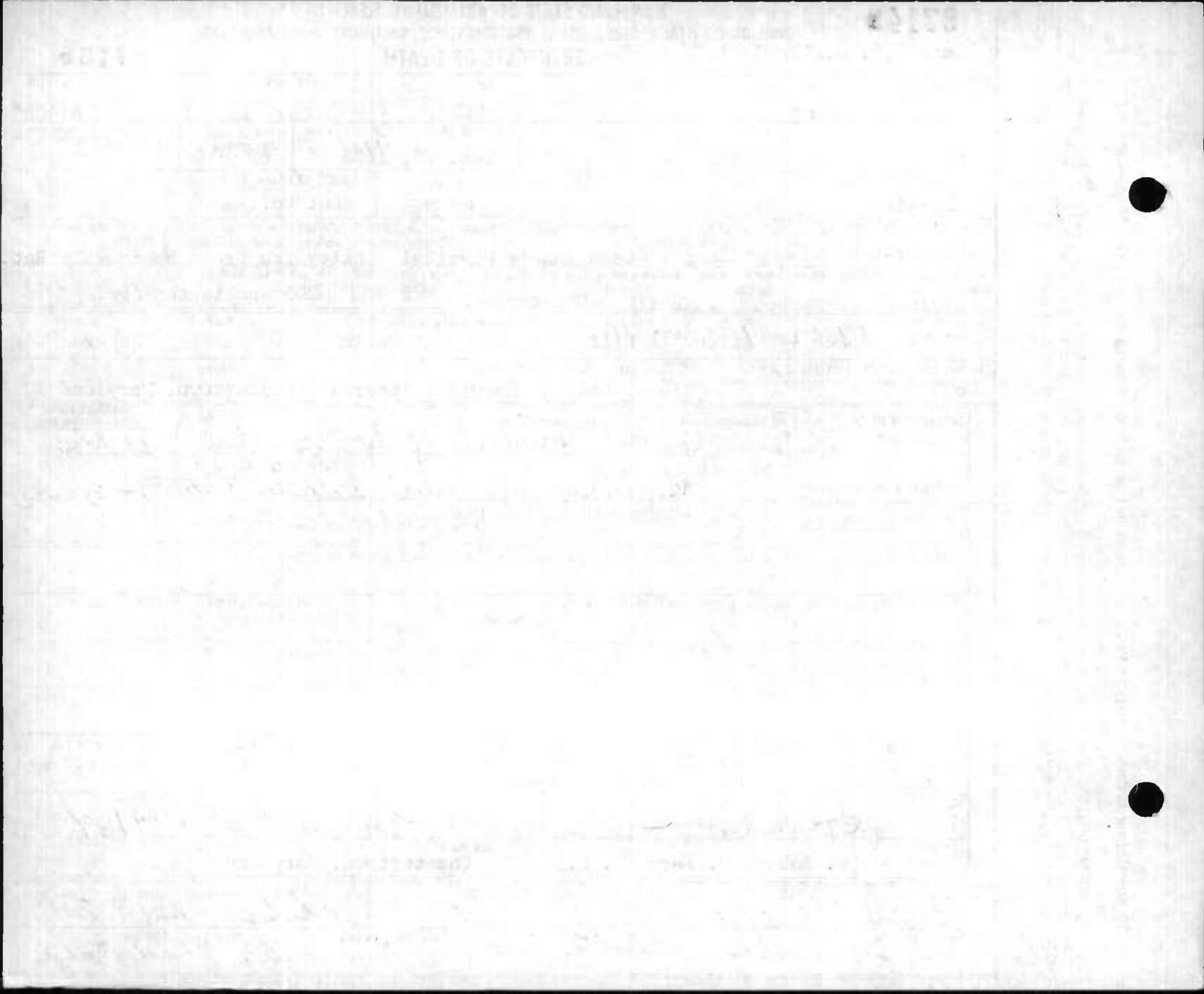
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items#5,6,14, Film#G401 5/31/68km CERTIFICATE OF DEATH

07155

1. DECEASED NAME (Type or print)	First Henry	Middle NMN	Lost Gill	20. DATE OF DEATH Month May 13, 1968	2b. HOUR 4:40PM
3. SEX Male	4. RACE White	S. DATE OF BIRTH Dec. 29, 1898	6. AGE (In years lost birthday) 69 70 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent Co., Md.		
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Dairy Ice Cream Business - Ret.	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. CITY OR TOWN Kent	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 205 Washington Ave.		
14. FATHER'S NAME Charles James Lee Allen Gill	First Middle Last Allen Gill	15. MOTHER'S MAIDEN NAME Della	Middle Hepbron		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO. 216-49-8648	17. INFORMANT Hospital Records	Address Chestertown, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Central monolysis (probable brain stem in relation to disease)</i> 18 hours 4120 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension & arteriosclerotic cardiac vascular disease</i> 15 years (c) <i></i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443X					
19a. DATE OF OPERATION X MEDICAL CERTIFICATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from May 13, 1968, to May 13, 1968, that (I) (we) last saw the deceased alive on May 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Robert W. Farr</i>	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 5/14/68		
22d. PHYSICIAN'S NAME (Type)	Mr. Robert W. Farr, M. D.	22e. ADDRESS Chestertown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/15/68	23c. NAME OF CEMETERY OR CREMATORIAL Chestertown Cemetery	23d. LOCATION (City or Town) Chestertown	(County) Talbot	(State) Md.
24. FUNERAL DIRECTOR Mauri V. Williams	ADDRESS Chesapeake Md.	25a. REC'D. BY REGISTRAR M.A. 17 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print)		First Leroy	Middle NMN	Lost Harris	2d. DATE OF DEATH Month 5 Day 5 Year 68	2b. HOUR 10:15
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH 4-23-1919			6. AGE (In years lost birthday) 49 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0
7b. BIRTHPLACE (State or foreign country) Galena	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent		
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent-Queen Anne	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farm Hand			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Kent	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
14. FATHER'S NAME First James	Middle Fredrick	Lost Harris	15. MOTHER'S MAIDEN NAME First Hennretta	Middle ?	Lost Benson	Address
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. ?	17. INFORMANT Kent - Queen Anne Hospital Chestertown, Md.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours			
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Subarachnoid hemorrhage -						
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension & Aneurysm						
DUE TO, OR AS A CONSEQUENCE OF (c) Don't know						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)						
19a. DATE OF OPERATION 4/4/38		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING □ CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.) 575	21f. LOCATION Street or R.F.D. No. 575	City or Town Chestertown	County Kent	State Md.
22a. I certify that (I) (this hospital) attended the deceased from 5/5/68 , to 5/5/68 , that (I) (we) last saw the deceased alive on 5/5/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Robert W. Farr		DEGREE Robert W. Farr M.D.	ATTENDING PHYS. Robert W. Farr M.D.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5/17/68
22d. PHYSICIAN'S NAME (Type) Robert W. Farr M.D.		22e. ADDRESS Chestertown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May, 11, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Olivet M.E. Church Cemetery Galena,	23d. LOCATION (City or Town) Galena,	(County) Kent,	(State) Md.	
24. FUNERAL DIRECTOR Edward Fellows Millington, Md.	ADDRESS	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE MAY 10 1968		

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FOR STATE
HEALTH DEPT.

Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR	
ELWOOD RAY KENDALL					<input checked="" type="checkbox"/>			5/16/68	4:20 P.M.	
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.					
male	white	9/24/1944	23 YRS.	MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED DIVORCED	9. COUNTY OF DEATH							
Kent Co. Md.	USA	<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	Kent							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
Lynch	Jewell Grain Elevators				Laborer				grain	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Maryland	Kent	Lynch	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Last			
Louis E. Kendall				Anna Usilton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
Yes	1965 - 67			216 44 8449 Anna Kendall			Lynch, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 913.9									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Short	
DUE TO, OR AS A CONSEQUENCE OF (b) Buried under grain which fell on top of him. DUE TO, OR AS A CONSEQUENCE OF (c)										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause }										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 9253										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY?	
									<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR MIN. 4:15 P.M. 5/16 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) See above						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Jewell Grain Elevators		21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
				Lynch		Kent		Maryland		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)								22b. DATE SIGNED
Robert W. Farr										5/16/68
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/19/68		23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery			23d. LOCATION (City or Town) Chestertown, Md.		(County)	(State)
24. FUNERAL DIRECTOR J.Wells Wells		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE MAY 21 1968			25b. REGISTRAR'S SIGNATURE jCharles Judge			

40170

and to god in love above your beholding.

good day to you all

and kind regards to all well here

1 Item 21 film 400
5-27-68 mt MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

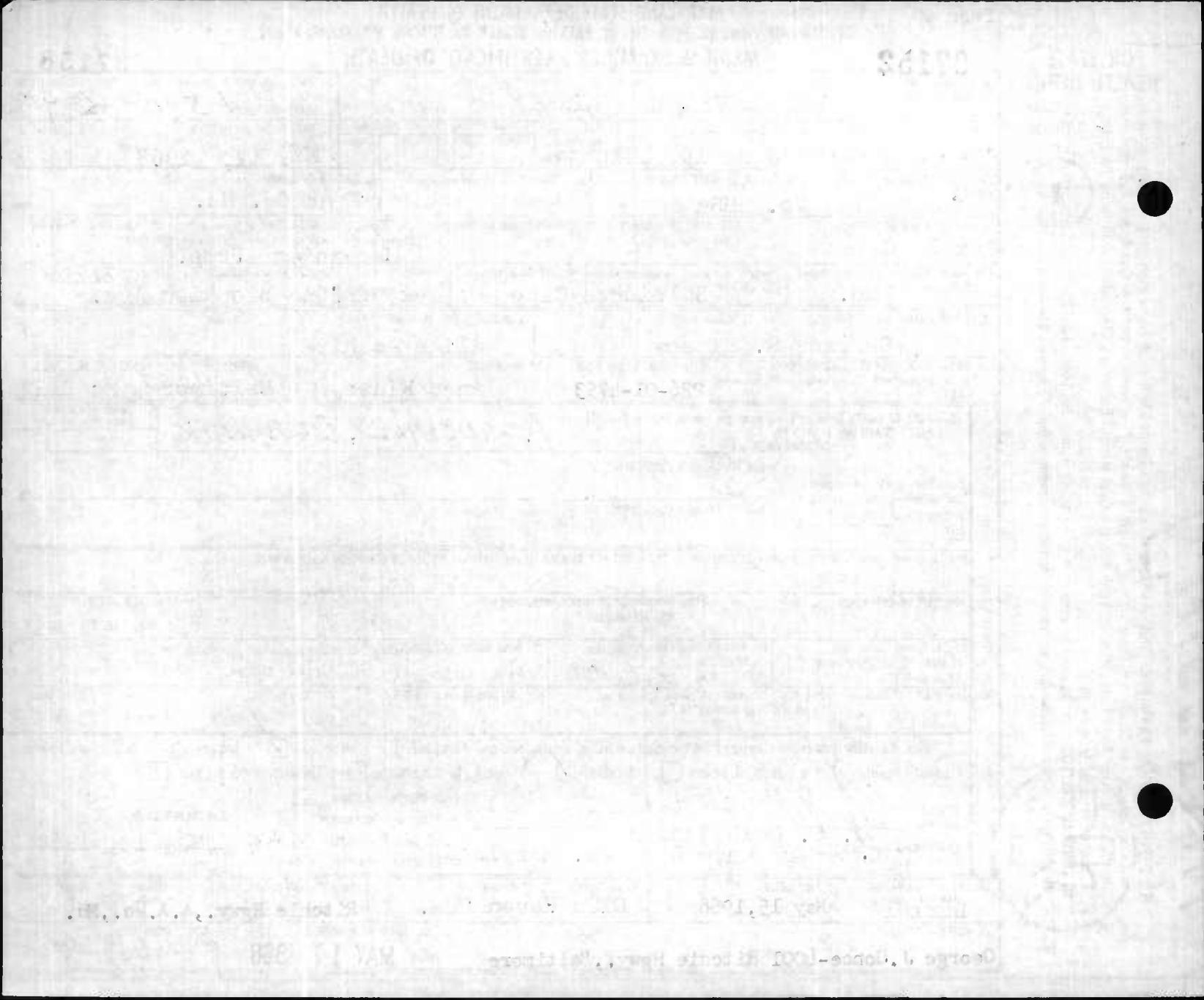
07152

17158

1. DECEASED NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF DEATH ESTI- MATED	Month	Day	Year	2b. HOUR	
		ROY CLEVELAND KINSEY			<input checked="" type="checkbox"/>	5	11	1968	9 A.M.	
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year				
male	white	June 15, 1910	57 yrs.			May	12, 1968	19	2d. HOUR	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH			Kent Co. Md.			
Boonsmill, Va. USA										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Rural Galena					Machinist Prop.					
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		Baltimore City			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3615 Brooklyn Ave. 21225			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
		Charles S. Kinsey			Alice Abshire					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT		ADDRESS			
no		226-01-4753			Anna Kinsey		3615 Brooklyn Baltimore, Md 21225			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>830.0</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>ACCIDENTAL DROWNING</u>										—
19a. DATE OF OPERATION <u>750X</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>10 AM 5-11 1968</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>apparently fell from boat</u>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Farm</u>			21f. LOCATION Street or R.F.D. No. City or Town County State <u>Rural Galena Kent Md</u>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22b. DATE SIGNED
ACTUAL SIGNATURE <u>J. S. Gulbrandsen</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					<u>May 12, 1968</u>
EXAMINER'S NAME (Type) <u>J. S. Gulbrandsen</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Actg					
ADDRESS (Street, city, town, or county) <u>Chestertown, Kent Co. Maryland</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>May 15, 1968</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Glen Haven Cem.</u>			23d. LOCATION (City or Town) <u>Ritchie Hwy., A.A. Co., Md.</u>		(County) (State)	
24. FUNERAL DIRECTOR <u>George J. Gonce - 4001 Ritchie Hwy., Baltimore</u>		ADDRESS			25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE			
					DATE <u>MAY 17 1968</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

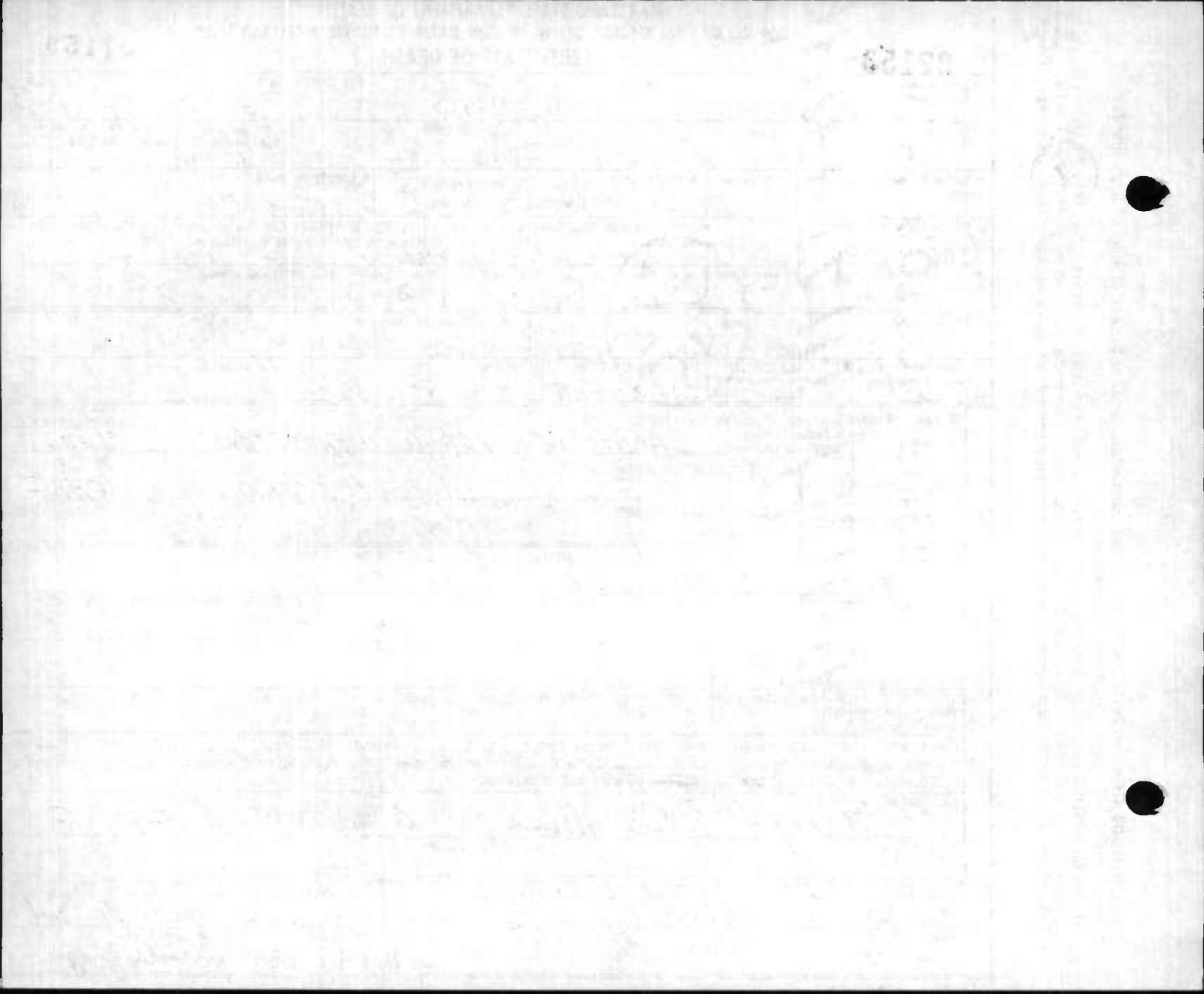
07159

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Fill in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First <i>Margaret</i>	Middle <i></i>	Lost <i>Oliver</i>	2a. DATE OF DEATH Month <i>5</i> Day <i>10</i> Year <i>1968</i>	2b. HOUR <i>8:55 AM</i>			
3. SEX <i>F</i>		4. RACE <i>W</i>	5. DATE OF BIRTH <i>12-4-84</i>		6. AGE (In years last birthday) <i>83</i> YRS.	IF UNDER 1 YEAR MONTHS <i></i>	IF UNDER 24 HRS. HOURS <i></i>	MIN <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Kent Co.</i>				
10. CITY OR TOWN OF DEATH <i>Chester town</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Kent-Queen Anne's Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>-</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Kent</i>	13c. CITY OR TOWN <i>Lynch</i>	13d. INSIDE CITY LIMITS? <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>	13e. STREET AND NUMBER <i>-</i>				
14. FATHER'S NAME First <i>Thomas</i>		Middle <i>John</i>	Lost <i>Oliver</i>	15. MOTHER'S MAIDEN NAME First <i>Ruth</i>	Middle <i></i>	Last <i>Miller</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>		16b. SOCIAL SECURITY NO. <i>214-32-6909</i>		17. INFORMANT <i>Hosp. records</i>	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>410.0</i> Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>A.S.C.V.D., Hypertension</i> (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>430.1 PROBABLE CARCINOMA LT. BREAST</i>									YEARS
19a. DATE OF OPERATION <i>4/20/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <i>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></i>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State			
22a. I certify that (I) (this hospital) attended the deceased from <i>5-6</i> , 19 <i>68</i> , to <i>5-10</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>5-10</i> , 19 <i>68</i> , and that in (my) (<i>our</i>) opinion death occurred on the date and hour and from the causes stated above, (I) (<input type="checkbox"/> did) (<input checked="" type="checkbox"/> did not) view the body after death.									
22b. SIGNATURE <i>Harry P. Ross M.D.</i>		22c. DEGREE <i>M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED <i>5-12-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Harry P. Ross, M.D.</i>		22e. ADDRESS <i>Chester town, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 13/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Marys Ep. Cemetery, Chestertown, Maryland</i>		23d. LOCATION (City or Town) <i>Chestertown</i>		(County) <i>Caroline Co.</i>	(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>Marvin L. William Chestertown Md.</i>		ADDRESS <i></i>	25a. REC'D BY REGISTRAR <i></i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
			DATE <i>May 17 1968</i>						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon paper. **Do not sign page 3.** Then please detach for use as the burial permit. **Do not sign page 3.** and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. DECEASED NAME (Type or print)		First Sadie	Middle Rebecca	Lost Roy	2d. DATE OF DEATH Month May Day 31, 1968 Year	2b. HOUR 4:40 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
Female		Negro		Feb. 14, 1900					
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Kent Co.			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Worton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rt. #1		
14. FATHER'S NAME First John		Middle Henry	Lost Jones	15. MOTHER'S MAIDEN NAME First Mary		Middle Matilda	Lost Hance		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 219-14-3028		17. INFORMANT Hospital Records		Address Chestertown, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Generalized carcinomatosis</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?
174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		<i>Carcinoma of rt breast</i>							? years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION 170X		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from May 29 , 1968, to May 31 , 1968, that (I) (we) last saw the deceased alive on May 31 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>A. C. Dick, M.D.</i>		22c. DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	DATE SIGNED 5-31-68		
22d. PHYSICIAN'S NAME (Type) A. C. Dick, M.D.		22e. ADDRESS Chestertown, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) 6-8-68		23b. DATE 6/4/1968		23c. NAME OF CEMETERY OR CREMATORIAL Union Cemetery		23d. LOCATION (City or Town) R. F. 2 Worton Kent, Md.		(County) Kent	(State) Md.
24. FUNERAL DIRECTOR <i>Berneth Waller, Chestertown, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			DATE JUN 5 1968

most numerous & largest
→ ~~most~~ the greatest

75-14-2

July 1968

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

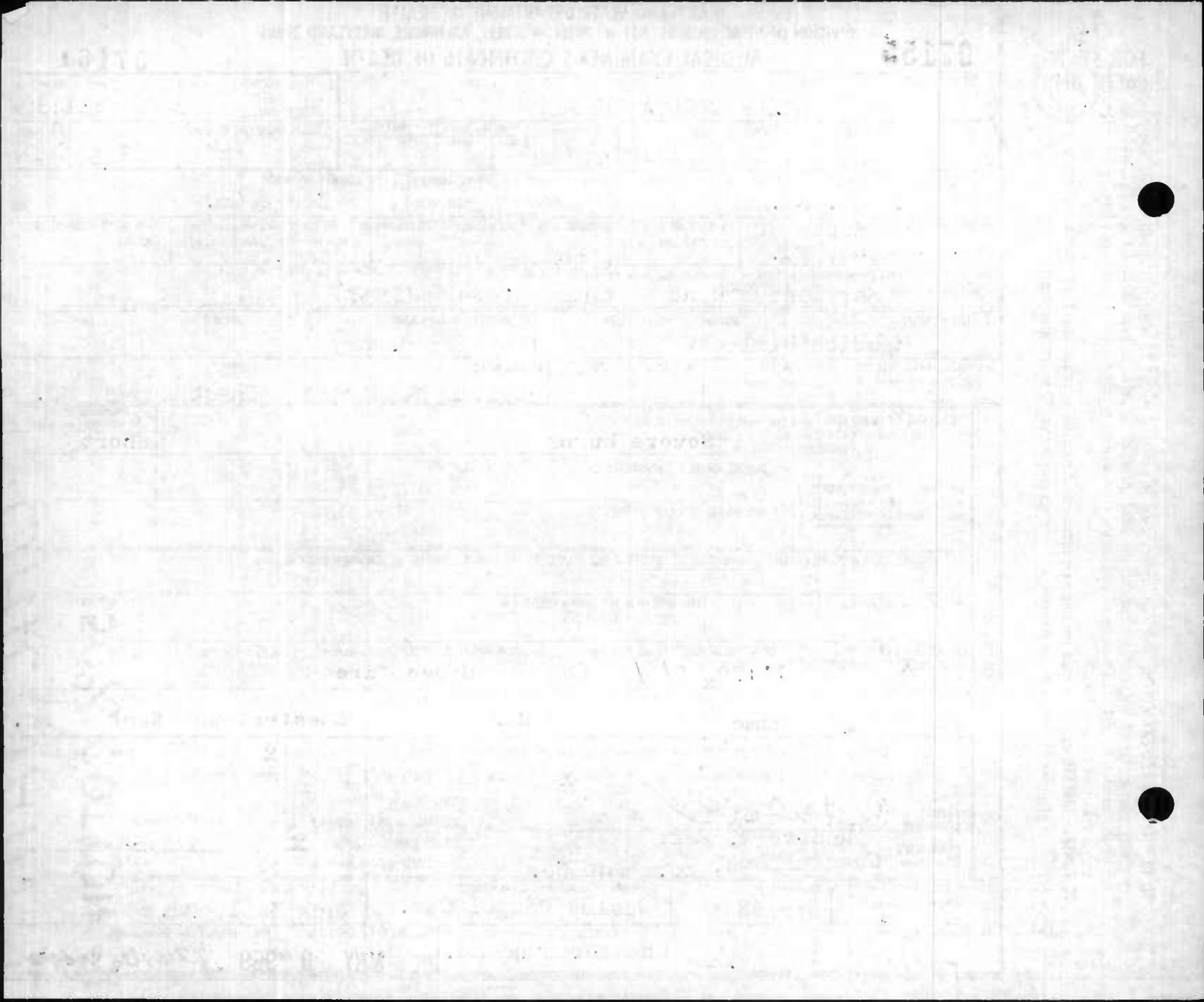
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

07155

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07161

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR
					<input checked="" type="checkbox"/>	5	6	1968	19 11 :30M
3. SEX		4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
female		white	10/18/1914	53 yrs.	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8.	MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH
Kent Co. Md.		USA							Ken t Co.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Route 20 Chestertown, Md.		at home		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland		Kent		Chestertown		YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	Rural	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
		Maurice Willson			Ida Downey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
no		(If yes give war or dates of service)		Sylvia Middleton - Chestertown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe burns 890X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Short
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 9160									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 11:30 P.M. 5/6/1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) House fire					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home		21f. LOCATION Street or R.F.D. No. REF City or Town County State Chestertown Kent Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									22b. DATE SIGNED 5/6/68
ACTUAL SIGNATURE <i>Robert W. Farr</i>		EXAMINER'S NAME (Type) Chestertown, Md. Kent Co.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS(Street, city, town, or county) Rock Hall, Md.					
23a. REMOVAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/9/68		23c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel Cem.		23d. LOCATION (City or Town) (County) (State) Rock Hall, Md.			
24. FUNERAL DIRECTOR <i>J.Wells Wells</i>		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE MAY 9 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



07156

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

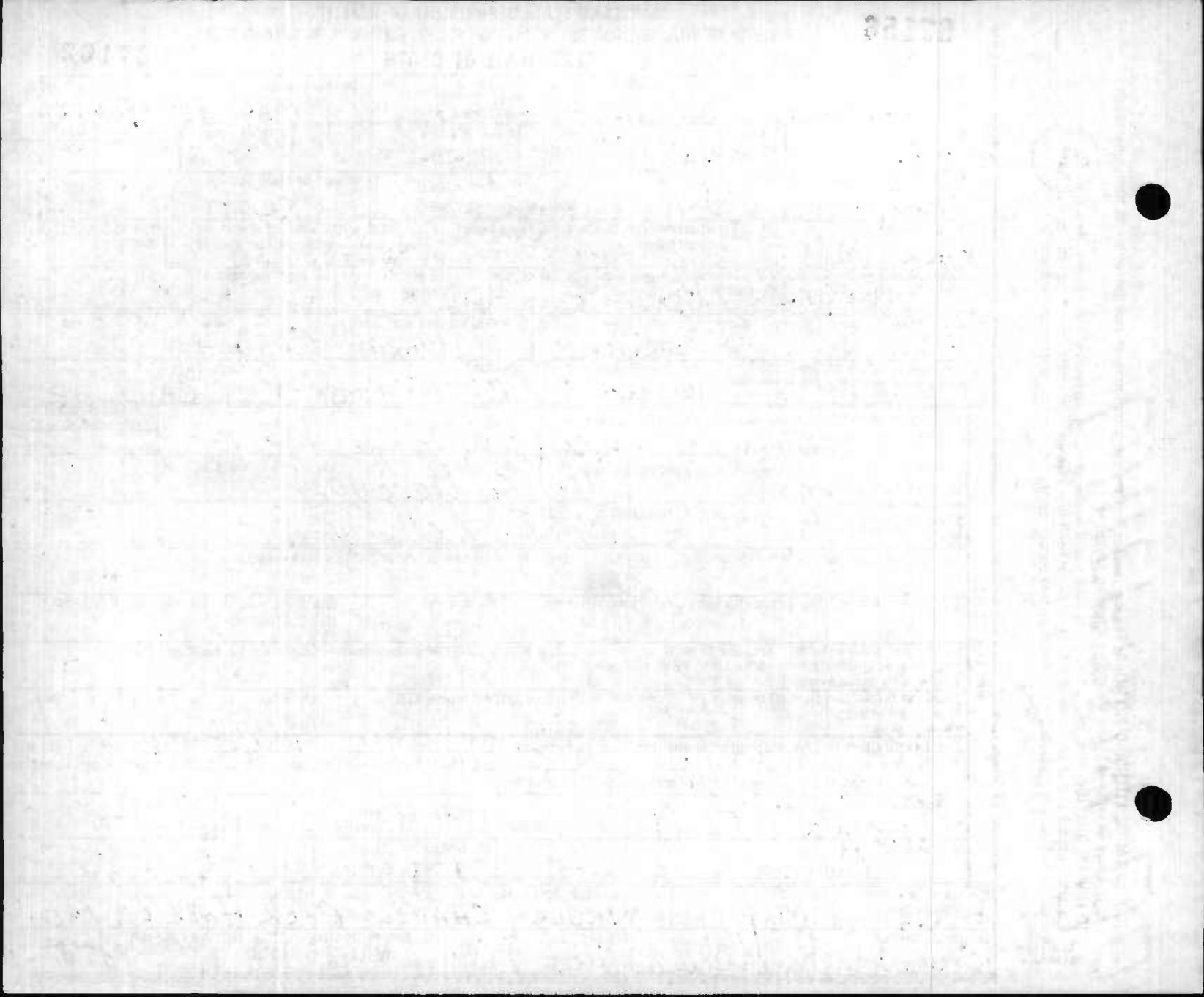
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Items#5&6 Film#G400 5/23/68 km

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. *Re 3 and 2
should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.*

1. DECEASED-NAME (Type or print)				First	Middle	Last	2d. DATE OF DEATH		2b. HOUR								
CARROLL WILSON SHRIVER						MAY 15 1968	Month Day Year	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. BIRTHPLACE (State or foreign country)		8. CITIZEN OF WHAT COUNTRY?		9. COUNTY OF DEATH					
MALE		WHITE		12-16-1876		92 YRS.		MARYLAND		USA		KENT					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER XX			
Rock Hall		XX		WATERMAN		XX		MARYLAND		KENT		Rock Hall		XX			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		Address	
THOMAS		SHRIVER	MARIA CROUCH		218-16-6582		MRS. E. PLUMMER - Rock Hall MD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4129 DUE TO, OR AS A CONSEQUENCE OF Cardio Vascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)												PART 2					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. LOCATION Street or R.F.D. No.		City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> , 19 <u>63</u> , to <u>May 15, 19<u>68</u></u> , that (I) (we) last saw the deceased alive on <u>May 15</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>Norbert C. Nitisch</i>				22c. DATE SIGNED 5/16/68											
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Rock Hall, MARYLAND															
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE MAY 17		23c. NAME OF CEMETERY OR CREMATORIAL Wesley CHAPEL		23d. LOCATION (City or Town) ROCK HALL		(County) MD.									
24. FUNERAL DIRECTOR		ADDRESS Edgar L. Lane - Church Hill Ind.		25a. REC'D. BY REGISTRAR DATE MAY 20 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>											



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

87157

87163

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) Walter			First	Middle	Last	2a. DATE OF DEATH Month 5 Year 68	2b. HOUR 84 M	
3. SEX Male		4. RACE Colored	5. DATE OF BIRTH 2/28/1893			6. AGE (In years lost birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Kent County,		Md.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) At Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Labor		12b. KIND OF BUSINESS OR INDUSTRY Farm	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 232 Cannon Street		
14. FATHER'S NAME First Fredrick		Middle	Last Wallace	15. MOTHER'S MAIDEN NAME First Sarah		Middle	Last Carrol	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. WW1 211-16-4181		17. INFORMANT Mrs. Marion Wallace Chestertown, Md.		Address 232 Cannon Street		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 YEARS								
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A. S. C. V. D</p> <p>4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last) (b)</p> <p>DUE TO, OR AS A CONSEQUENCE OF (c)</p> <p>DUE TO, OR AS A CONSEQUENCE OF (c)</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)</p> <p>4221</p>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 11-28-66 , 19 66 , to 5-22- , 19 68 , that (I) (we) lost saw the deceased alive on 5-22- , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE J.A. Oteiza		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 5/27/68		
22d. PHYSICIAN'S NAME (Type) J.A. Oteiza		22e. ADDRESS Chestertown, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/29/68		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Pleasant Cem.		23d. LOCATION (City or Town) R.F.D. Chestertown, Md.	(County) None	(State) None
24. FUNERAL DIRECTOR Denatha Wally		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE JUN 3 1968		25b. REC'D BY JUDGE John J. Judge		

